**Introduction**

Within the tumors of the head and neck, squamous cell carcinoma of the external auditory canal has a low incidence and prevalence, 1-6/1,000,000 inhabitants per year [1-3]. Due to the lack of reported cases, it is a great challenge for the otolaryngologist to carry out a correct staging as well as an adequate therapeutic protocol, an overview of the literature refer it with a wide range of clinical presentation, being more common in patients of the fifth or sixth decade of life, with a broad clinical picture concordant with: otalgia, purulent/hematic otorrhea, conductive hearing loss, and also in some cases with facial palsy, temporomandibular joint dysfunction or preauricular tumor.

**Case Report**

75-year-old female patient with family history of cancer in two siblings, exposure to biomass smoke for more than 200 hours/year since her childhood, traumatic history: a car accident suffered one year ago with concussion in right temporal region, without requiring hospital management without apparent complications, but since then, she started feeling intermittent singing and burning otalgia on the right ear and ipsilateral hearing loss, and three months later she also had intermittent right hematic otorrhea. She denied vertigo and/or hyperthermia. She received treatment on multiple occasions with topical and systemic antibiotic with mild improvement and post-term exacerbation of symptoms. At the physical examination, the right ear was reported as normoinsert not-painful-to-manipulation pinna, otoscopy shown an EAC obstructed in 90% in its internal third by a spherical, smooth, whitish lesion with epithelial features and no evaluable pedicle, that obstructed the 90% of the right EAC at the inner third, rest of the evaluation without alteration of the mandibular dynamics, cylindrical neck without palpable masses, mobile central trachea with crepitus, an incisional biopsy of the right EAC tumor was performed and the anatomopathologic reported was an in situ squamous cell carcinoma.
right elongated and left shortened Schwabach. No compromise of 
mandibular dynamics. Facial mimics and the rest of cranial nerves 
examination remained normal [4-6].

A computerized tomography (Figure 2) and simple and 
contrasted magnetic resonance imaging (MRI) were performed as 
diagnostic aids (Figure 3). In the tomography an isodense tumor
at the expense of soft tissue was observed occupying the right CAE
in its internal third of approximately 6*8*12 mm with apparent
erosion in its previous wall, respecting the middle ear. In the MRI
sequence T1 a homogeneous isointense lesion, brain tissue like, was
identified occupying the internal portion of the right EAC without
invasion of the middle ear. In the T2 sequence a communication from
the extension pedicle to the anterior wall of the EAC was visualized,
with no invasion of the parotid space, then at the office an incisional
biopsy was performed under local anesthesia, taking an irregular
light brown and soft edges, 0.6x0-4x0-3 cm out in size sample,
with histopathological result of squamous cell carcinoma in situ.

With this result, our patient was protocolized with the Pittsburgh
TNM staging; a T2N0M0 score was given for which the treatment
protocol was based on a stage II. It was decided to perform a lateral
resection of the right temporal bone with radical mastoidectomy
(Figure 4), to complement the surgical treatment a right superficial
parotidectomy (Figure 5) and a selective suprahomohyoid neck
dissection (SND level I-III) was also done [7-9].

Discussion
Squamous cell cancer is an entity with slight incidence and
prevalence and with lesser bibliography or guides well established
for its treatment. Within patient staging, the University of
Pittsburgh-modified TNM classification, suggested by Arriaga 1990, modified by Moody [10], has allowed a standardization of the classification, treatments and results of the patients. Surgical resection is a crucial in the treatment, an early surgical intervention is associated with an increased survival, depending of the clinical stage correlated with the therapeutic algorithms can give us the accurate management (Figure 6). Cure rates have been increasing sin 1970 due to the progress of imaging diagnosis and improvement in skull base microsurgery. Actually in the literature, Gidley reported a 5-year survival of 48% for T1 and T2 stages and 28% for T3 and T4 stages.

Tumors with extension to periauricular soft tissue as well as parotid space had a better evolution compared to those that spread to the mastoid or to the rest of the divisions of the temporal bone. The possible reason is due to the routes of dissemination of the natural foramina of the bone. Within the dissemination pathways, we can mention the fissures and channels of the temporal bone such as branches for the auditory canal, canal of the posterior auricular nerve, canal of the auriculotemporal nerve, tympanic cord and vascular channels, among others. Resection of tumors involving periauricular soft tissue leads to more reliable tumor-free margins without the need to resect vital structures and a possible second reconstruction [13-15].

In cases of nodal affection, radical neck dissection is accepted within the literature, therefore is a different case for the N0 presentation, which remains controversial. Approximately 4.5 to 31.8% of nodes are positive for neck dissection. The case of micro metastasis with clinically negative neck is 17% [16]. Until day, there is no evidence in the literature that support the decision not to treat the neck, so a prophylactic dissection can be performed. The type of neck dissection is still controversial. An accepted choice is the dissection of levels Ib to III together with a block resection and superficial parotidectomy. The risk of metastasis at level IV is considered in cases of positive nodes at higher levels or in recurrent tumor after surgery and / or radiotherapy [17,18].

**Conclusion**

Nowadays, squamous cell carcinoma of the EAC still being a therapeutic challenge for the different specialists involved in its diagnosis and management, whether medical or surgical. Without specific treatment guidelines due to their low incidence, the attending physician must have an extensive knowledge of the literature as well as the anatomy and surgical techniques, have a good medical center with an adequate multidisciplinary team and offer the best therapeutic according on the needs of the clinical stage. A fundamental part of the diagnosis is based on the clinical presentation, although not specific, is a guideline. Persistent fetid otorrhea despite adequate medical treatment, together with progressive chronic otalgia and absence of clinical data on malignant otitis externa, we consider this enough reason to rule out oncological pathology within the differential diagnosis of chronic otorrhea.

**References**


